RONALD H. SCHUSTER, M.D., P.A.

RONALD H. SCHUSTER,

M.D.

JEFFREY SCHREIBER, M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I HAVE REC	EIVED A COPY OF THIS OFFICE'S NOTIC	CE OF PRIVACY PRACTIC	ES.
Please Print	Name:	-	
Signature:		Date:	
I GIVE PERMISSION TO RELEASE MY MEDICAL INFORMATION TO THE FOLLOWING:			
	motherfather		spouse
other (specify)			
Signature		Date	
	For Office	e Use Only	
	d to obtain written acknowledgement of recement could not be obtained because:	eipt of our Notice of Privacy	Practices, but
	Individual refused to sign		
	Communications barriers prohibited obtaining the acknowledgement		
	An emergency situation prevented us from obtaining acknowledgement		
	Other (Please Specify)		

10807 Falls Road, Suite 101 Lutherville, MD 21093